colon, and barium issued from the colostomy opening. No sign of an obstructive growth of the colon was seen, and a tentative diagnosis of volvulus was made. Uncertainty as to the exact nature of the obstruction, his advanced years, and his erstwhile moribund condition were the factors that led to a decision to send him home with a colostomy belt and with the proviso that if all went well his case was to come up for review in three months' time.

Three weeks after this there was a prolapse of about 2 in. (5 cm.) of gut through his colostomy opening, which we successfully reduced. On Jan. 13, 1946, we were hastily summoned and found more than a foot (30 cm.) of gut prolapsed through the colostomy opening. The appearance was that of a dark sausage-like mass issuing from the colostomy. We endeavoured on two occasions in the next few hours to reduce the intussusception without success. The patient was in good condition, without pain or even discomfort. Mr. Hamilton Bailey came down and wrapped the intussusception in a towel and squeezed it for some moments in order to reduce the oedema. This appeared moderately successful. He then proceeded to attempt to reduce the apex in accordance with the orthodox method of reducing a paraphimosis. This also was partially successful, but about 4 in. (10 cm.) still remained without. Up to this time the patient had had but little pain. An effort was made with greater force, and the surgeon's thumb passed right through the mucous membrane and entered the peritoneal cavity, some clear peritoneal fluid escaping. Shortly after this some of the intussusception which had been reduced was extruded. The patient was sent to hospital. Under general anaesthesia Mr. Bailey freed the colostomy opening (with the intussusception protruding therefrom) from the abdominal wall and delivered 18 in. (45 cm.) of distal redundant colon and about 8 in. (20 cm.) of proximal colon. The intussusception had begun in the colon proximal to the colostomy opening. Before proceeding further it was ascertained by intra-abdominal palpation that there was no growth or other abnormality to account for the original obstruction. The two limbs of the colon were anastomosed by the Paul-Mikulicz procedure, and the intussusception, together with the redundant portion of the colon, was excised. The total length of colon removed, which included the intussuscepted portion, was nearly 3 ft. (90 cm.). The patient made a good recovery.

COMMENTARY

Intussusception is usually seen only when the abdomen is opened by the surgeon on the operating table, but the exceptions are the rare types that extrude through a colostomy or similar artificial opening, and those rare ones seen passing out through the anus. Very few cases of the former type have been recorded—one, by Milligan (1926) of an intussusception through an enterostomy and one by Turner (1936) in an article on the various complications of colostomies. The latter case was the only one in 175 cases of various complications of colostomies. Both these cases were treated in the same way as the one described above.

We are indebted to Mr. Hamilton Bailey for his co-operation and kind help in the preparation of this report.

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Plant Dermatitis in the Bahamas

The shrub *Metopium toxiferum*—"poison wood" or "poison bark"—flourishing throughout the open spaces of the Bahama Islands and in southernmost Florida (where it is also known as "doctor's gum"), has attracted little attention outside the immediate vicinity. Yet it contains a toxin at least as powerful as that of the well-known North American "poison ivy" (*Rhus toxicodendron*), thereby entitling this colonial product to at least a short note.

Botanical Note.—The plant *M. toxiferum*, of the family Spondiaceae (Small, *Florida Trees*, p. 60), varies in size from a small shrub to a tree 40 ft. (12.2 m.) high (Britton, *Bahamas Flora*, p. 244). The bark is thin and brown, with a moist, green, shining layer beneath, which becomes orange with increasing age. Its branches are widely spreading, and the leaves, up to a foot (30.48 cm.) long, alternate, with three to seven ovate, pinnate, glabrous leaflets, bright green and shining on top and dull on the under surface. The efflorescence is a many-flowered compound raceme with short pedicle. Florets have five short ovate sepals, five white separate petals, and five separate stamens with large anthers. The fruit is a green drupe, becoming yellowish when ripe.

The Toxin.—This is contained in the "milk" beneath the bark, in the leaves, and in the fruit. On the bark and leaves it frequently oozes up to the surface, where it or some other product associated with it in the juice becomes oxidized and produces black stains. It is a type of gum resin, very similar to that of poison ivy.

CLINICAL NOTE

Many R.A.F. personnel engaged on clearing undergrowth around the station were affected. Among the white residents there is regularly at the New Year a crop of cases of poison-wood dermatitis, following the incautious gathering of Christmas trees.

After contact with the toxin there are usually no symptoms for a few days, when small papules, rapidly becoming vesicular, appear at the site of contact, with considerable itching and variable surrounding erythema. Superficial ulceration of these vesicles occurs, and the rash spreads both locally and to distant parts of the body. Crops of small, deep-set papulo-vesicles appear on face, trunk, and legs. Local weeping and crusting eczematization may occur, and the whole process continues for weeks after the initial contact. Sometimes the reaction is more urticarial, with gross erythema and oedema affecting and directly spreading from the contact area. In less sensitive people retrogression of the rash may occur at any stage. In one patient blisters up to an inch (2.5 cm.) in diameter formed over hands, forearms, body, face, and legs, breaking down to superficial ulcers, some of which became secondarily infected. The appearance resembled a papulo-necrotic tuberculide. He was febrile on admission, and remained in hospital 20 days.

SENSITIVITY TO THE TOXIN

One drop of juice from the underbark of a plant 5 ft. (1.52 m.) high was placed on the forearm of each of twenty volunteers. One developed a generalized spreading rash lasting several weeks, one a severe local erythematous reaction, 12 local papulation of varying degree, and 6 were unaffected. On my own arm itching occurred a few minutes after application, followed by the characteristic black staining and the development of a small papule by the next day. The local area became eroded after four days, with superficial ulceration and surrounding vesiculation. Resolution started on the seventh day. One drop of berry juice, however, caused a widespread erythematous vesicular eruption lasting some weeks. (This was not due to acquired hypersensitivity, since subsequent drops from the bark actually produced less reaction than the first.)

The phenomenon of generalized spread to non-contact areas seemed to indicate the production of a general allergic cutaneous tissue reaction of systemic dissemination. However, the possibility existed that the original toxin or product of it lurking in the blister fluid at the contact site was carried over the body by the patient's finger, producing multiple local reactions. Blister fluid from one patient with the disseminated rash was therefore tested on other parts of his own skin and on the skin of other sensitive subjects, with and without previous excoriation of the skin by a needle. In no case was any lesion produced, so that the hypothesis of contact spread would seem to be disproved.

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Traumatic Axillary Venospasm

This condition has been described by various people, especially Matas, and was first recognized about 60 years ago. It occurred most commonly on the right side, and various theories have been advanced to account for it. Sudden abduction of the arm may cause trauma to the axillary vein by contact with the subclavius muscle; this may either give rise to a generalized venospasm or actually damage the intima of the vein, with venospasm and thrombosis, hence the name "traumatic axillary vein thrombosis." Matas says that there is a polyvalent causation, in indirect trauma to the vein and its immediate environment, including lymphatics and perivenous sympathetic plexus, and that thrombosis is not essential.

The case described below is one of traumatic axillary venospasm without thrombosis, and in this instance the opportunity of observing the veins and brachial artery was taken. The brachial artery was very sensitive and the slightest handling was sufficient to put it into spasm, so apparently there must be a generalized increased sensitivity of the neurovascular make-up of this particular patient to account for the condition. The treatment adopted—cervical sympathetic block—does not claim to be original, but I have not seen any reference to it. The cervical sympathetic block has a twofold effect—viz., it relieves the venospasm, and also the arteriospasm, which in time will increase the venous return.

CASE REPORT

The patient was a female aged 35, married, but with no children, and was admitted complaining of swelling of the left arm, which was tense but not very painful. She said that four hours ago, when putting her left arm into her overcoat sleeve, she felt something